MEDICAID OFF-ISLAND REFERRAL

The Medicaid program covers eligible recipients for necessary off-island medical services that are not available on island.

1. **OFF ISLAND REFERRAL PACKET:**
    - Off-Island Referral Form: To be completed by the referring physician and submitted with:
        - Supporting medical records such as laboratory/pathology results, X-ray/CAT scan/MRI reports, consultation reports, EKG report, etc.
        - If a Nurse Practitioner signs referral, a physician *MUST* co-sign referral.

    - MEDIF FORM: To be completed by the attending/referring physician within 10 days of departure and signed by the physician and patient/authorized representative
        - If oxygen is needed, **OXYGEN REQUEST FORM** (Guam to Honolulu & Guam to Manila) and **PHYSICIAN'S STATEMENT FOR POC** (Honolulu to U.S) must be attached.

    - Other Health Insurance Documents: If the patient has a primary insurance (private insurance or Medicare).
        - Appointment Card
        - Statement of Coverage
        - Denial of Airfare with explanation (if not covered by primary insurance)

2. **REVIEW OF REFERRAL REQUEST:**
   The BHCFA Office will review the off-island referral for approval or denial:
    - Approved: Medical records will be sent to an off-island provider for review and acceptance. As soon as the appointment is made, the client will be informed accordingly.
        - Arrangements will be made by the BHCFA Off Island Coordinator

    - Other Insurance: The primary insurance carrier will make the initial arrangements with the provider for the appointment.

3. **LODGING AND GROUND TRANSPORTATION ARRANGEMENTS**

   Room and board, Lodging, and Food are the patient's responsibility.

    - Guam Medical Referral Office (GMRO): **671-477-4676**
        - Information regarding off-island lodging arrangements, fees and ground transportation while on a medical referral status.

Off-Island Medical Providers:

- Children's Hospital Los Angeles – Los Angeles, California
- Good Samaritan Hospital – Los Angeles, California
- The Medical City – Manila, Philippines

BHCFA

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), BHCFA may not use or disclose your health information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

I, _____ hereby authorize the following person (s) to disclose my health information and receive these disclosures of my health information:

1. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

2. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

3. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

4. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

5. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

By signing below, I hereby acknowledge that I have read and understand the aforementioned process and I agree that the health information submitted herewith will be used and disclosed for the following reasons:

- Treatment purposes.
- For payment or redirect a third party liability payment for treatment.
- For healthcare operations.

_____ _____

Printed Name and Signature of Patient or Authorized Representative Date

_____

If signed by authorized representative, indicate relationship to patient

Department of Public Health and Social Services
Division of Public Welfare
Bureau of Health Care Financing

OFF-ISLAND CARE REFERRAL FORM

Patient's Full Name	DOB	Case No.	Hospital No.

Current Address	Telephone No.	Third Party Coverage ☐YES ☐NO
		☐Medicare ☐SelectCare ☐Pacificare
		☐Staywell ☐Multicover ☐Other_____

Detailed Description Of Patient's Health Problems:

Purpose For Sending Patient Off-Island:

Accepting Facility:

Contact was made on:_____

Accepting Physician:

Contact was made on:_____

Date of Departure: Appointment Date:

Approximate Date of Return:

Patient's Certification: I authorize any holder of medical or other information about me concerning my illness or treatment to be released to the Department of Public Health and Social Services or its authorized representatives.

_____ _____
Signature (Patient or Authorized Representative) Date

Attending Physician Signature:

Date:

Action	Consultant Physicians Signature:
☐ Approved ☐ Disapproved Reason:_____ _____ _____	Date:

NOTE: Please attach necessary Medical Summary and all pertinent findings for medical review.

MEDICAID
OFF-ISLAND PROGRAM BENEFIT LIMITATIONS

Please **place initials** to indicate that you have read and understood the following:

_____ I understand that off-island medical treatment **requires Prior Authorization and for services not available on island only.**

_____ I understand that **cardiac artificial valves/stents, pacemakers, intraocular lens (IOL) are covered services.**

The following services are *not* covered – palliative and/or experimental treatments, AICD, orthopedic appliances (covered under ABP), and the anticipated device:
_____ Patient Initial: _____

_____ I understand that in the event of death, **cargo transportation service, casket, and mortuary/funeral service are not covered.**

_____ I understand that roundtrip air travel is provided to an eligible patient. **Patient must return to Guam within the next day after clearance from the specialist and/or hospital.**
If the patient is a minor, one (1) parent and/or one (1) medical escort when medically necessary.
If the patient is ABP, one (1) companion for specific procedures, one (1) medical escort for specific procedures when medically necessary, and additional escort for specific procedures when medically necessary and unable to self-care.

_____ If I have a primary insurance, I understand that I am responsible in **obtaining necessary documents from my primary insurance, regarding coverage, approval/denial of the off-island medical referral to include appointments with the accepting off-island provider.**

_____ I understand that I must be **FINANCIALLY READY for the cost of meals, ground transportation, lodging, outpatient medications and any exclusion of medical services and/or co-payment and deductibles.** (Please note: If applicable, meals, lodging, and outpatient medication may be reimbursed upon submission of original invoice/receipts. Reimbursement shall not exceed $25 per day for meals and $50 per day for lodging.)

_____ I understand that I am responsible for **expenses incurred with non-participating medical providers.**

_____ If approved, I shall **ensure to inform my eligibility specialist/caseworker that I will be going off-island for medical treatment** and that my **eligibility under the program is current and valid for three months.**

By signing below, I hereby acknowledge that I have read and fully understand the aforementioned program's limitations and my responsibilities and obligations.

_____ _____
Printed Name and Signature of Patient/Authorized Representative Date

_____
Relationship to Authorized Representative